GUIDELINES

Letters to the Editor, discussing material recently published in the *Journal*, are welcome. They will have the best chance of acceptance if they are received within 8 weeks of an article's publication. Letters to the Editor may be published with a response from the authors of the article being discussed. Discussions beyond the initial letter and response will not be published. Letters submitted pertaining to published Discussions of articles will not be printed. Letters to the Editor are not usually peer reviewed, but the *Journal* may invite replies from the authors of the original publication. All Letters are published at the discretion of the Editor.

Letters submitted should pose a specific question that clarifies a point that either was not made in the article or was unclear, and therefore a response from the corresponding author of the article is requested.

Authors will be listed in the order in which they appear in the submission. Letters should be submitted electronically via PRS' *e*nkwell, at www.editorialmanager.com/prs/.

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The *Journal* requests that individuals submit no more than five (5) letters to *Plastic and Reconstructive Surgery* in a calendar year.

Letters

Bioengineered Breast: Concept, Technique, and Preliminary Results

Sir:

We read with interest the article titled "Bioengineered Breast: Concept, Technique, and Preliminary Results" by Maxwell and Gabriel.[1] The concept of "bioengineering" the breast using acellular dermal matrix and fat grafting has revolutionized prosthetic-based reconstruction; the authors' contribution to the literature in this field is significant. The authors detail their method using acellular dermal matrix and fat grafting to augment the soft-tissue envelope in breast reconstruction during the second stage of breast reconstruction. They use 2-0 Prolene (Ethicon, Inc., Somerville, N.J.) sutures threaded on straight Keith needles, placed in a parachuting fashion, to secure acellular dermal matrix under the muscle in the superomedial aspect of the breast. The sutures are brought out through the mastectomy skin, tied in an air-knot, and covered with Tegaderm (3M, St. Paul, Minn). We have a small refinement to offer when affixing the acellular dermal matrix to the breast pocket. We have used a knotless suture system, a bidirectional 2-0 PDO Quill suture (Surgical Specialties Corp., Braintree, Mass.) on straight needles. After the acellular dermal matrix has been introduced into the implant pocket, the sutures are then placed with the needles directed in an oblique and cephalad direction to capture as much of the subcutaneous tissue as possible before piercing through the skin (Fig. 1). The sutures are then pulled taut and cut at the skin level. This is an absorbable suture that allows the acellular dermal matrix to be placed adherent to the implant pocket without the need for needle threading, knot tying, or suture removal in the future. We believe this is an easier method of securing the acellular dermal matrix to the implant, which also lessens the risk of pocket contamination of a suture, which is both inside the implant pocket and on the surface of the skin.

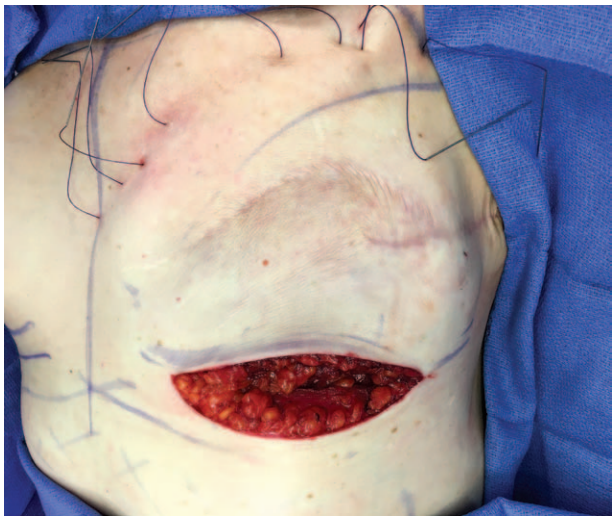

Fig. 1. Position of sutures after placement of the knotless suture system in securing the acellular dermal matrix to the implant pocket. Note that the sutures exit the skin cephalad to the entry point in the subcutaneous tissue to capture the maximum amount of subcutaneous tissue to prevent suture slipping without skin dimpling.

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DISCLOSURE

The authors have no financial interest to declare in relation to the content of this communication.

REFERENCE

1. Maxwell GP, Gabriel A. Bioengineered breast: Concept, technique, and preliminary results. *Plast Reconstr Surg.* 2016;137:415–421.

Reply: Bioengineered Breast: Concept, Technique, and Preliminary Results

Sir:

We appreciate the comments and the refinements to the upper pole placement of the acellular dermal matrix using the bioengineered breast. Minimizing contamination within the implant pocket by using techniques that will achieve this is always welcome.

The principle of bioengineered breasts includes using cells, regenerative matrices, and highly cohesive gel implants. These principles are used both in a prepectoral and a dual-plane position in reconstructive surgery. This principle also extends to aesthetic revision procedures when similar reinforcements and additions are needed to create an aesthetically pleasing form. Upper pole acellular dermal matrix is sometimes placed posterior to the pectoralis major and sometimes anterior to it. In either case in which the upper pole acellular dermal matrix is being placed, we appreciate the comments by Drs. Zhang and Blanchet with their suggested refinement to this technique.

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DISCLOSURE

The authors are consultants for Allergan and LifeCell.

Lipofilling of the Breast Does Not Increase the Risk of Recurrence of Breast Cancer: A Matched Controlled Study

Sir:

We read with great interest the article by Kronowitz et al. in the February issue of *Plastic and Reconstructive Surgery*.[1] As enthusiasts of lipofilling of reconstructed breasts, we congratulate the authors on the effort to prove that this is indeed not only an extremely valuable technique, but also safe for post–breast cancer patients. It is, to our knowledge, the largest observational study to date on one of the most important questions in our field. It will have a significant impact on the plastic surgery community and will be largely discussed by our colleagues.

However, some issues with the reporting of the findings limit the extent to which readers can understand the findings and may ultimately jeopardize the conclusions. The most relevant measure of disease occurrence reported in the Results section are the average incidence rate (0.25 case per 100 person-years in cases versus 0.65 case per 100 person-years in controls) and cumulative recurrence risk (1.6 percent versus 4.1 percent at 5 years). These results show a risk of recurrence approximately 2.5 times higher in the control group and, if directly compared, could suggest that lipofilling might be protective for locoregional recurrence. Even if not statistically significant, this is not a negligible difference. However, recurrence-free survival time was defined as the interval from the date of mastectomy to the date of first locoregional recurrence or the date of last follow-up, biasing the estimated risk in the lipofilled group, a form of bias in survival analysis known as immortal time bias,[2] as subjects at a higher risk of recurrence after mastectomy probably had a lower chance of receiving a posterior lipofilling procedure. This could single-handedly explain the observed difference between the groups. As stated in the article, one of the possible approaches to this issue is the use of the time-dependent Cox proportional hazard regression model. However, in Table 3, where the results for this analysis are presented, the hazard ratios and their confidence interval are omitted, and the conclusions are based solely on the calculated p values. Assuming that a value of $p > 0.05$ means that there is no difference between groups is a common misconception of the meaning of the p value (p value fallacy).[3] Adequate reporting of the results of the statistical model should include the measures of disease association and their confidence interval, allowing readers to adequately evaluate the difference in risk observed between the groups.

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DISCLOSURE

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